HEALTH HISTORY & MEDICAL FORM

Family Name___________________________________ **Home Phone**_________________________
Street Address_________________________________ **City**__________________**Zip**__________
Parent/Guardian____
Family Doctor__________________________________ **Phone Number**______________________

HEALTH HISTORY

If the medical information provided last year is the same for this year, you may simply indicate "current", then sign and date form.

CHILD'S NAME **CHILD'S NAME** **CHILD'S NAME**

____

Immunizations: (YEAR of last immunization or last time person had the disease)

Tetanus/Diphtheria ____
Chicken Pox ____
TB (results) ____
Measles ____
Mumps ____
Rubella____
Polio ____
Other ____

Special Information: Please check all that apply-information strictly confidential

Sleep Walking ____
Blackouts ____
Fainting ____
Nosebleeds ____
Severe Headaches ____
Asthma ____
Kidney Problems____
Seizures____
Diabetes____
Frequent Colds ____

Allergic Reactions: (please list all know medicinal allergies) and type of reaction.

____
____

Please indicate any other medical problems/situations pertinent to your child:

____

Any physical limitations?___ If yes, explain____

Any emotional/psychological limitations or reactions to be aware of? If yes, explain.

____

Is the student taking medication? _____________
If so, list medications. ____

____

In an **Emergency**, and unable to reach parent/guardian, contact:
Name____ Phone__________________________

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In case of an emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

SIGNATURE____ DATE ________________

FAMILY INSURANCE PROVIDER/HEALTH PLAN ____

HEALTH PLAN POLICY NUMBER ____